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## **Define, Inform, Dictate and Deliver**

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In October 2014, Simon Stevens, the chief executive of NHS England, committed the service to plugging £22bn of the expected £30bn gap in its finances by 2020 through productivity gains of 2% or 3% a year by 2020. Since that announcement the Government promised to provide £8bn by 2020 whilst this may notionally have been received but it has not alleviated the severity of these financial constraints.

With austerity measures biting even deeper into the budgets of NHS organisations, all staff are under pressure to make cost efficiencies while at the same time, improve operational standards and patient outcomes. Within this pressured change environment there are those hospitals and departments that have embraced the demand for change, creating innovative skills mix platforms from which to deliver services, and those who have remained entrenched in operational protocols. In both scenarios, the overarching driver for service (re) design has been operational efficiency guided by Government targets.

With real engagement in patient centred care and outcomes based healthcare, it is now time to reevaluate the how operational practice is determined and success measured beyond efficiency. Consequently the first question that must be asked is “what are the desired outcomes of our service?” To be truly meaningful, this needs to be determined at the service department level with service leads engaging meaningfully with patient groups to define appropriate outcomes and the measures of achievement. It is essential that this is undertaken at different stages of the patient pathway as desired outcomes will vary depending on the service being experienced and while there may be some commonality, service derived measurable outcomes defined in partnership with patient groups will ensure staff from the range of disciplines and departments can engage meaningfully in process and examine how their individual practice contributes to defined outcomes.

Outcome measures are only of value if they are shared publicly and performance against them measured meaningfully. These outcome measures, defined in partnership with departmental staff and patients, should inform the strategic direction of the organisation. NHS organisations are charged with delivering cost effective care appropriate to the community they serve. As such, beyond cost efficiency drivers and throughput targets for certain disease groups, the care priorities embodied within organisational strategy should reflect and build on the defined outcomes and their associated measures. In this way, the organisation can meaningfully engage with delivering care appropriate to the community it serves.

Strategy, as we know, is an empty vessel unless it can be operationalised. In any large organisation, there are barriers and enablers to change, supporters and disablers. However, in order to meet the defined outcomes that have informed strategy, then the strategy must dictate the operational practice and employee activities. If the strategy does not dictate or direct practice then one must

question the value and purpose of the strategy. Of course change in practice is always associated with tension and anxiety. However, as both departmental staff and patient groups have been involved in defining the outcomes and measures that have informed the strategy, any change in service delivery and practice necessary to ensure achievement of outcomes can be rationalised and the benefits to staff, patients and community articulated.

However, change in practice should not be instigated without a clear explanation of how the defined outcomes might be delivered and measured. The actions of individuals must reflect operational processes in order to deliver defined outcomes. Once again, managers must engage all members of the team in this process and value each individual contribution to the achievement of outcomes.

We have, of course, presented a cyclical ideology of hospital management that some may describe as idealistic. However, healthcare organisations are charged with engaging staff, patients and community at all levels of delivery. Surely simplifying the process into clearly demarcated but inter-related actions will allow everyone to implement measureable and meaningful service outcomes that extend beyond financial efficiency and targets.

Indeed, this is what NHS England (2016) has acknowledged, they observed that these complexities were impacting on the way hospitals performed. They argue the single most beneficial change would be to tackle the problem of delayed discharges, which is caused by a lack of available services in the community to take care of frail patients when their medical care had finished. Without that support being provided - either from council care teams or district nursing - these patients cannot be discharged. This brings us to simplified integrated provision, through integrated care provision patient experience can be improved, greater efficiency achieved and value from health delivery systems. The aim must be to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.

A decision about the intensity of integration and simplifying processes is essential, starting with links across services, coordinating teams or pooling resources. Where there is a strong history of partnership working, further steps to amalgamate into a single integrated organisation with leaner systems is vital. Though this may not always be feasible it should be a strategic intent. Although integration that is focused largely on bringing organisations together is unlikely to create improvements in care for patients. A careful understanding and analysis of the goals of integration and structural change is critical in order to establish what might help or hinder progress. There is a pressing need for a shared vision in which the service user perspective and patient experience is central. This will then shape how, when and where to integrate services in order to improve patient care and enhance operational efficiency.

In conclusion, the whole of the NHS is under tremendous pressure, not only in terms of supply but the ability to supply the resources to complete the tasks at hand. We acknowledge the approach is not a panacea for all of the ills which afflict the NHS but it may be a solution for some.

References

NHS England (2016) Our 2016/17 Business Plan. <http://tinyurl.com/zbbbq8u> (accessed 31 January 2017)